Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RICARDO MURILLO MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name

EMPLOYERS ASSURANCE CO

Carrier's Austin Representative Box

Box Number 34

MFDR Tracking Number

M4-12-0693-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER FAILED TO PROPERLY PAY THIS DESIGNATED DOCTORS CLAIM EVEN AFTER THE CLAIM WAS SENT BACK TO CARRIER AS REQUEST FOR RECONSIDERATION."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier timely audited the initial medical bill from the designated doctor and reimbursed $350 for Maximum Medical Improvement (MMI) evaluation according to Rule 134.204(j) (3), $300 for the Impairment Rating (IR) evaluation of the left upper extremity (shoulder, elbow, wrist) pursuant to Rule 134.204 (j) (4), Subparagraph (C) because a full physical examination with range of motion was performed, an additional $150 for the impairment rating evaluation of the lumbar spine and an additional $150 for the impairment rating evaluation of the head/facial contusions. In addition, the carrier reimbursed $50 for the second (multiple) impairment rating. Carrier's total reimbursement was $1,000. The carrier respectfully disagrees that an additional $150 is owed to the designated doctor. Upon closer review of the Designated Doctor Evaluation narrative report, there is no indication the designated doctor completed a full physician examination of the lumbar spine, the facial or head contusions. As a result of this review, the carrier's position is it overpaid $300 for two additional body areas (lumbar spine and facial/head contusions.)"

Response Submitted by: Employers Assurance Company, P. O. Box 71088, Charlotte, NC 28272-1088

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2011	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits dated September 21, 2011
   - 1 – The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 1 – We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health. (Z951)

Issues

1. Is the respondent's claim adjustment reason code "1, Z951" supported?
2. Were the services in dispute appropriately billed?
3. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. According to the explanation of benefits dated September 21, 2011, the carrier reduced the medical bill based on "1 – We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health. (Z951)." The respondent did not clarify or otherwise address the "1, Z951" claim adjustment code upon receipt of the request for dispute resolution. No documentation was provided to support that there is a contract between the provider and any network, or that notification to the health care provider was provided in accordance with 28 Texas Administrative Code §133.4. For these reasons, the Division finds that the "1, Z951" is not supported. Therefore, the dispute will be reviewed in accordance with 28 Texas Administrative Code §134.204.
2. The requestor billed the amount of $1,100.00 for CPT code 99456-W5-WP with 4 (four) units/areas in Box 24G of the CMS-1500 for a Division ordered Designated Doctor Examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division order on the EES14 and DWC032 was to determine Maximum Medical Improvement/Impairment Rating (MMI/IR). An additional line item was also billed with CPT code 99456-MI representing multiple impairments for $50.00. The respondent re-audited the billing and determined that no additional reimbursement was due when reviewing both codes together.

   28 Texas Administrative Code §134.204(j)(4)(C) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:

   (I) spine and pelvis;

   (II) upper extremities and hands; and

   (III) lower extremities including feet).

3. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the documentation supports that MMI was assigned and 2 body areas were rated, the spine and the upper extremities. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions are reviewed. The Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the MAR per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(II)(a) for the 1st

musculoskeletal area using Range of Motion (ROM) method on the compensable chest (upper extremities) is $300.00 and Diagnosis Related Estimates (DRE) Category 1 method used on the 2nd musculoskeletal area on the lumbar spine (spine) is $150.00. The requestor also billed for the "head", however, no documentation was found to support what services were provided specific to the "head". The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-W5-WP is $800.00. Since there are only 3 musculoskeletal areas rather than 4, and only 2 areas were rated, the combined MAR for the MMI and 2 units for the IR areas is $800.00.

4. The respondent has previously reimbursed the requestor the amount of $950.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 30, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.